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<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

## Filing at a Glance

Company:	Doctors Direct Insurance, Inc.
Product Name:	DDI 2014 Rate and Rule Filing
State:	Illinois
TOI:	11.2 Med Mal-Claims Made Only
Sub-TOI:	11.2023 Physicians & Surgeons
Filing Type:	Rate/Rule
Date Submitted:	10/03/2013
SERFF Tr Num:	DDIC-129211551
SERFF Status:	Closed-Withdrawn
State Tr Num:	DDIC-129211551
State Status:	
Co Tr Num:	
Effective Date	01/01/2014
Requested (New):	
Effective Date	
Requested (Renewal):	
Author(s):	Bowen Susan
Reviewer(s):	Gayle Neuman (primary), Julie Rachford
Disposition Date:	01/28/2014
Disposition Status:	Withdrawn
Effective Date (New):	01/28/2014
Effective Date (Renewal):	01/28/2014
State Filing Description:	
Routed	11/06/13

**State:** Illinois  
**TOI/Sub-TOI:** 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons  
**Filing Company:** Doctors Direct Insurance, Inc.  
**Product Name:** DDI 2014 Rate and Rule Filing  
**Project Name/Number:** /

## General Information

Project Name: Status of Filing in Domicile: Pending  
Project Number: Domicile Status Comments: We would like to withdrawal this filing and re-submit at another time. Please confirm receipt of this message or let me know if additional information/processes are needed.

Thank you,

Susan

Reference Organization:

Reference Number:

Reference Title:

Advisory Org. Circular:

Filing Status Changed: 01/28/2014

State Status Changed:

Deemer Date:

Created By: Bowen Susan

Submitted By: Bowen Susan

Corresponding Filing Tracking Number: DDIC-129211551

Filing Description:

2014 Rate/Rule Manual filing, IL

## Company and Contact

### Filing Contact Information

Kenneth Ludwig, President & CEO  
1140 Lake Street  
Suite 500  
Oak Park, IL 60301

kenneth.ludwig@ddiimail.com  
630-574-9800 [Phone] 3 [Ext]  
866-422-2300 [FAX]

### Filing Company Information

Doctors Direct Insurance, Inc.  
1140 Lake Street  
Suite 500  
Oak Park, IL 60301  
(630) 574-9800 ext. [Phone]

CoCode: 12843  
Group Code:  
Group Name:  
FEIN Number: 06-1791609

State of Domicile: Illinois  
Company Type:  
State ID Number:

## Filing Fees

Fee Required? No  
Retaliatory? No  
Fee Explanation:

## State Specific

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<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
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Refer to our checklists prior to submitting filing ([http://www.idfpr.com/DOI/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.htm](http://www.idfpr.com/DOI/Prop_Cas_IS3_Checklists/IS3_Checklists.htm)): x

Refer to our updated (04/06/2007) SERFF General Instructions prior to submitting filing. They have been updated to clarify what rates and rules are required to be filed as well as what rates and rules are not required to be filed. Also, the "Product Name" is the Filing Title and not the Project Number.: x

NO RATES and/or RULES ARE REQUIRED TO BE FILED FOR LINES OF COVERAGE SUCH AS COMMERCIAL AUTO (except taxicabs), BURGLARY AND THEFT, GLASS, FIDELITY, SURETY, COMMERCIAL GENERAL LIABILITY, CROP HAIL, COMMERCIAL PROPERTY, DIRECTORS AND OFFICERS, ERRORS AND OMISSIONS, COMMERCIAL MULTI PERIL just to mention a few. However, a Summary Sheet (RF-3) is required to be filed. Please refer to the State Specific Field below for what rates/rules are required to be filed and to our checklists for specific statutes, regulations, etc. :

[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.asp](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp) .: x

Medical Malpractice rates/rules may now be submitted using SERFF effective January 1, 2012.: x

The only rates and/or rules that are required to be filed are Homeowners, Mobile Homeowners, Dwelling Fire and Allied Lines, Workers' Compensation, Liquor Liability, Private Passenger Automobiles, Taxicabs, Motorcycles and Group Inland Marine Insurance which only applies to insurance involving personal property owned by, being purchased by or pledged as collateral by individuals, and not used in any business, trade or profession per Regulation Part 2302 which says in part, "each company shall file with the Director of Insurance each rate, rule and minimum premium before it is used in the State of Illinois.": x

When selecting a form filing type for a multiple form filing, use the dominant type from these choices: APP - application; CER - certificate; COF - coverage form; DPS - declaration page; END - endorsement; POJ - policy jacket; ORG - Companies adopting an Advisory or Rating Organization's filing. Example: If you are submitting a policy as well as endorsements, a declaration page and an application, you would select "POL" for policy.: x

<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
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<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Gayle Neuman	01/28/2014	01/28/2014

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Julie Rachford	01/08/2014	01/08/2014
Pending Industry Response	Amanda Wiggers	11/13/2013	11/13/2013
Pending Industry Response	Amanda Wiggers	11/06/2013	11/06/2013

#### Response Letters

Responded By	Created On	Date Submitted
Bowen Susan	01/16/2014	01/16/2014
Bowen Susan	11/15/2013	11/15/2013
Bowen Susan	11/12/2013	11/12/2013

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Susan Bowen	Bowen Susan	11/15/2013	11/15/2013

<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

## Disposition

Disposition Date: 01/28/2014  
Effective Date (New): 01/28/2014  
Effective Date (Renewal): 01/28/2014  
Status: Withdrawn

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Explanatory Memorandum		Yes
Supporting Document	Form RF3 - (Summary Sheet)		Yes
Supporting Document	Certification		Yes
Supporting Document	Manual		Yes
Supporting Document	Request to Maintain Data as Trade Secret Information		Yes
Supporting Document	Susan Bowen		Yes
Rate	2014 Rate/Rule Manual		Yes

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<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/08/2014
Submitted Date	01/08/2014
Respond By Date	01/16/2014

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Dear Kenneth Ludwig,

### **Introduction:**

*This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:*

### **Objection 1**

*Comments: Certification that the company's rates are based on actuarially sound principals and are consistent with the company's experience is required by an officer of the company and a qualified actuary. Please submit a certification to this effect at first opportunity.*

*To demonstrate rating factors are applied objectively and not subjectively, please explain the standards for determining whether an association qualifies for a 5% membership credit as referenced in Section Two, paragraph VI.F of page 5.*

*Section Two, Paragraph VII.B.1. of page 6 and Section Three, paragraph I.A. of page 8 fail to identify the criteria for determining which calculation will be applied to compute premium amounts. Please outline the criteria for determining the premium calculation.*

*According to Section Three, paragraph IV of page 9 of the Proposed Rating Manual, the schedule rating maximum debit is 50%. Please adjust to be in compliance with CB 2011-05, which limits schedule rating debits/credits to +/- 25%.*

### **Conclusion:**

*Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>*

*Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:*

*[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.asp](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp)*

*Please submit compliant form(s) no later than the date shown above or the entire filing may be disapproved. Please be advised that when the Director disapproves the form(s) you must immediately cease using the form(s) in Illinois.*

*Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.*

*Sincerely,*

*Julie Rachford*

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**State:** Illinois **Filing Company:** Doctors Direct Insurance, Inc.  
**TOI/Sub-TOI:** 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons  
**Product Name:** DDI 2014 Rate and Rule Filing  
**Project Name/Number:** /

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/13/2013
Submitted Date	11/13/2013
Respond By Date	11/28/2013

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Dear Kenneth Ludwig,

**Introduction:**

*This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:*

**Objection 1**

*Comments:*

Susan,

*You have indicated you have a red lined copy of the manual. Please attach the red lined version for our review. Thanks.*

**Conclusion:**

*Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>*

*Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:*

*[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.asp](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp)*

*Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.*

*Sincerely,*

*Amanda Wiggers*

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**State:** Illinois **Filing Company:** Doctors Direct Insurance, Inc.  
**TOI/Sub-TOI:** 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons  
**Product Name:** DDI 2014 Rate and Rule Filing  
**Project Name/Number:** /

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/06/2013
Submitted Date	11/06/2013
Respond By Date	11/20/2013

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Dear Kenneth Ludwig,

**Introduction:**

*This is to acknowledge receipt of your filing. Your submission is not acceptable for filing in Illinois due to the following reasons:*

**Objection 1**

*- Manual (Supporting Document)*

*Comments: Please highlight all changes from the previously filed manual.*

**Conclusion:**

*Sign up to get e-mail notification for updates to the Department's website. <http://insurance.illinois.gov/RSS/>*

*Please refer to the appropriate Property Casualty IS3 Review Requirements Checklist before submitting any filing. The checklists are available at the Department's Web site or at the following link:*

*[http://insurance.illinois.gov/Prop\\_Cas\\_IS3\\_Checklists/IS3\\_Checklists.asp](http://insurance.illinois.gov/Prop_Cas_IS3_Checklists/IS3_Checklists.asp)*

*Please give this matter your immediate attention. If you have any question regarding this filing please feel free to contact me.*

*Sincerely,*

*Amanda Wiggers*

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<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

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## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/16/2014
Submitted Date	01/16/2014

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Dear Gayle Neuman,

### **Introduction:**

### **Response 1**

#### **Comments:**

Thank you for your inquiries. We will have a response to you by the end of the month. Sorry for the delay. Your patience is appreciated.

### **Related Objection 1**

Comments: Certification that the company's rates are based on actuarially sound principals and are consistent with the company's experience is required by an officer of the company and a qualified actuary. Please submit a certification to this effect at first opportunity.

To demonstrate rating factors are applied objectively and not subjectively, please explain the standards for determining whether an association qualifies for a 5% membership credit as referenced in Section Two, paragraph VI.F of page 5.

Section Two, Paragraph VII.B.1. of page 6 and Section Three, paragraph I.A. of page 8 fail to identify the criteria for determining which calculation will be applied to compute premium amounts. Please outline the criteria for determining the premium calculation.

According to Section Three, paragraph IV of page 9 of the Proposed Rating Manual, the schedule rating maximum debit is 50%. Please adjust to be in compliance with CB 2011-05, which limits schedule rating debits/credits to +/- 25%.

### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### **Conclusion:**

Sincerely,  
Bowen Susan

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**State:** Illinois **Filing Company:** Doctors Direct Insurance, Inc.  
**TOI/Sub-TOI:** 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons  
**Product Name:** DDI 2014 Rate and Rule Filing  
**Project Name/Number:** /

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/15/2013
Submitted Date	11/15/2013

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Dear Gayle Neuman,

### **Introduction:**

### **Response 1**

#### **Comments:**

Thank you. I have submitted the red line copy under ammendments of this filing.

### **Related Objection 1**

Comments:

Susan,

You have indicated you have a red lined copy of the manual. Please attach the red lined version for our review. Thanks.

### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### **Conclusion:**

Sincerely,

Bowen Susan

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**State:** Illinois **Filing Company:** Doctors Direct Insurance, Inc.  
**TOI/Sub-TOI:** 11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons  
**Product Name:** DDI 2014 Rate and Rule Filing  
**Project Name/Number:** /

## Response Letter

Response Letter Status	Submitted to State
Response Letter Date	11/12/2013
Submitted Date	11/12/2013

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Dear Gayle Neuman,

### **Introduction:**

### **Response 1**

#### **Comments:**

I have a red-line copy which highlights the changes from our previous manual. Can I post that for review somewhere? Or did you want a list of the changes?

Thank you,  
Susan

### **Related Objection 1**

Applies To:

- Manual (Supporting Document)

Comments: Please highlight all changes from the previously filed manual.

### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### **Conclusion:**

Sincerely,  
Bowen Susan

<b>SERFF Tracking #:</b>	DDIC-129211551	<b>State Tracking #:</b>	DDIC-129211551	<b>Company Tracking #:</b>	
<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.		
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons				
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing				
<b>Project Name/Number:</b>	/				

## Amendment Letter

Submitted Date: 11/15/2013

Comments:

Attached Red Line copy for your review.

Changed Items:

*No Form Schedule Items Changed.*

*No Rate Schedule Items Changed.*

Supporting Document Schedule Item Changes	
<b>Satisfied - Item:</b>	Susan Bowen
<b>Comments:</b>	
<b>Attachment(s):</b>	RATING MANUAL - PROPOSED 2014 REDLINE.pdf

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<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

## Post Submission Update Request Processed On 01/28/2014

Status:	Allowed
Created By:	Bowen Susan
Processed By:	Gayle Neuman
Comments:	

### General Information:

Field Name	Requested Change	Prior Value
Status of Filing in Domicile	Pending	
Domicile Status Comments	We would like to withdrawal this filing and re-submit at another time. Please confirm receipt of this message or let me know if additional information/processes are needed.	
	Thank you, Susan	
Corresponding Filing Tracking Number	DDIC-129211551	

<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

## Rate/Rule Schedule

Item No.	Schedule Item Status	Exhibit Name	Rule # or Page #	Rate Action	Previous State Filing Number	Attachments
1		2014 Rate/Rule Manual		Replacement		RATING MANUAL - PROPOSED 2014 CLEAN.pdf

**DOCTORS DIRECT INSURANCE, INC.**

PHYSICIANS AND SURGEONS  
PROFESSIONAL LIABILITY INSURANCE

RATING MANUAL

ILLINOIS

**RATING MANUAL  
FOR  
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

**SECTION ONE – GENERAL RULES**

**I. APPLICATION OF MANUAL**

This manual provides rules, rates, premiums, classifications and territories that will be used by Doctors Direct Insurance, Inc. ("the Company") in providing Professional Liability to Physicians and Surgeons.

**II. COVERAGE FORM**

All policies will be written on a claims made basis.

**III. POLICY TERM**

Policies will be written for a term of one year, and renewed annually thereafter. The policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year for a short term policy period.

**IV. PREMIUM COMPUTATION**

A. Premiums at policy inception will be computed using rules, rates and rating plan in effect at that time.

B. When a policy is issued for other than an annual term, the premiums will be computed on a pro-rata basis.

**V. FACTORS OR MULTIPLIERS**

A. Unless otherwise indicated, factors or multipliers are to be applied consecutively and not added together.

B. Rate Modifications listed as % credits are applied multiplicatively as follows: rate x (1 – credit %) or rate x (1 + debit %).

**VI. POLICY WRITING MINIMUM PREMIUM**

The minimum annual premium shall be \$250 unless otherwise specified.

**VII. WHOLE DOLLAR RULE**

The final premium for each physician or surgeon for will be rounded to the nearest whole dollar as follows:

A. Any value involving \$.50 or more will be rounded up to the next highest whole dollar amount.

B. Any value involving \$.49 or less will be rounded down to the next lowest whole dollar amount.

**VIII. ADDITIONAL PREMIUM CHARGES**

A. All changes or additions involving additional premiums will be pro-rated based upon the effective date of the change.

B. The rates and rules that were in effect at the inception date of the policy period are to be used in all additional premium calculations. After computing the additional premium, charge the amount applicable from the effective date of the change.

C. Additional premiums of \$25 or less may be waived. This waiver only applies to charges due on the effective date of change endorsements.

**IX. RETURN PREMIUMS**

Return premiums are computed using rates in effect at the time the return premium is computed. Return premiums are computed pro rata and rounded in accordance with the whole dollar rule when any exposure is deleted, or an amount of insurance is reduced.

**RATING MANUAL  
FOR  
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

**X. POLICY CANCELLATIONS**

Return premiums for cancellations initiated by either the Company or the insured will be computed on a pro-rata basis, rounded to the next higher whole dollar.

**XI. PREMIUM PAYMENT PLANS**

The Company will offer the insured three (3) premium payment plans for every policy period.

Quarterly Installment Option

- a. An initial down payment of 25% of the total premium due at policy inception;
- b. The remaining premium spread equally among the second, third, and fourth installments and due 3, 6, and 9 months from policy inception, respectively;
- c. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Monthly Installment Option

- a. An initial down payment of 1/12<sup>th</sup> of the total premium due at policy inception;
- b. The remaining premium spread equally among eleven (11) monthly installments and due each month on the respective date equal to the date of the month in which the policy incepts.

Annual Pre-payment Option

See Section Two, Paragraph VI, Item I of this Rating Manual.

**SECTION TWO – RATING RULES**

**I. SPECIALTY CLASSIFICATIONS**

- A. Each physician is assigned a classification code according to his/her specialty. The specialty classifications and their associated rating factors are shown on the State Rate Page.
- B. For the purpose of determining each physician's specialty designation:
  1. The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia), and who do not ordinarily assist in surgical procedures.
  2. The terms "minor surgery" and "major surgery" may apply to general practitioners and specialists.
- C. The Company will assign specialty class based on the practice profile and procedures noted in the physician's application. The company may blend the rates of two or more specialty classifications based on the practice profile and procedures noted in the physician's application.
- D. If a physician's specialty is not listed on the State Rate Page, the physician will be assigned to the classification that applies to the most similar specialty listed.

**II. TERRITORIES**

- A. Territory assignments are based on each individual insured's practice as insured by the Company. Portions of the practice that are not insured by the Company are not considered.
- B. If an insured practices in two or more territories, the company may blend the rates of the applicable territories.
- C. The territory definitions and associated rating factors are shown on the State Rate Page.

**III. LIMITS OF LIABILITY**

**RATING MANUAL  
FOR  
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

- A. Basic Limits of Liability for Professional Liability Claims Made coverage under this program shall be \$1,000,000 Per Claim/\$3,000,000 Annual Aggregate.
- B. Alternate limits of liability are available. The limit options and associated rating factors are shown in the table below:

Limit of Liability		Limit Factor
Per Claim	Annual Aggregate	
\$250,000	\$750,000	0.640
\$500,000	\$1,500,000	0.780
\$1,000,000	\$1,000,000	0.970
\$1,000,000	\$3,000,000	1.000

- C. For limits greater than \$1,000,000 Per Claim / \$3,000,000 Annual Aggregate, refer to company.

**IV. PRIOR ACTS COVERAGE**

- A. The claims made coverage retroactive date is the initial effective date of continuous coverage by the Company, unless the Company and the insured agree that the retroactive date should precede the initial policy effective date.
- B. Once established, the retroactive date may be advanced only at the request of the insured or with the insured's written acknowledgment.
- C. When prior acts coverage is requested, the claims made year applicable is determined based on the retroactive date and the policy effective date as follows:
1. Determine the number of years between the retroactive date and the policy effective date. This figure is the number of years of prior exposure. Any fractional year difference between the retroactive date and the effective date is calculated on a daily pro-rata basis.
  2. The claims-made year is the years of prior exposure plus 1.
  3. For fractional claims-made years, the applicable claims-made step factor is calculated using straight line interpolation between factors for surrounding claims-made years.
- D. The following claims-made step factors are applied to the premium.

Claims-Made Year	Step Factor
1	0.300
2	0.550
3	0.775
4	0.925
5+	1.000

**V. BASE RATE**

The base rate is shown in the State Rate Page.

**VI. RATE MODIFICATIONS**

**A. Part Time Physicians**

1. Any insured whom the company determines to be practicing as a part-time practitioner will be eligible for a reduction in the otherwise applicable rate for that specialty. The credit for a part time practitioner is 25% for 10-20 hours per week and 50% for fewer than 10 hours per week.
2. The part-time credit is not applied to any Extended Reporting ("Tail") Policy rating unless the insured was rated part-time for at least 24 months prior to the effective date of an Extended Reporting Period Endorsement.

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FOR  
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3. No other credits are to apply concurrent with this rule except risk management and membership association credits.

**B. New Physician**

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
  - a. Residency;
  - b. Fellowship program in their medical specialty;
  - c. Fulfillment of a military obligation in remuneration for medical school tuition;
  - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A reduced rate will be applied in accordance with the credits shown in the table below:

Year of Practice	Credit
1 <sup>st</sup>	50%
2 <sup>nd</sup>	30%
3 <sup>rd</sup>	15%
4 <sup>th</sup>	0%

**C. Physician's Leave of Absence**

1. A physician who becomes disabled, or is on leave of absence for a continuous period of up to 180 days, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.
3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.
4. A written request must be received by the Company in order to be eligible for the restricted coverage and rate reduction.
5. A premium credit of 75% will apply during the period of disability or leave of absence.
6. The Company may extend the credit for a leave of absence beyond 180 days if circumstances so warrant.

**D. Physicians Military Leave of Absence**

1. A physician, who is on military leave of absence may be eligible for restricted coverage at no premium charge during the leave of absence period. This will apply retroactively to the first day of the leave of absence. Only one application of this credit may be applied to an annual policy period.
2. A written request must be received by the Company within 30 days of the first day of the disability or leave of absence, in order to be eligible for the restricted coverage and premium waiver.

**E. Schedule Rating**

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

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The premium for a policy may be modified in accordance with a maximum credit or debit modification indicated on the State Rate Page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the following specific considerations.

Characteristics	Max Credit	Max Debit
Cumulative Years of Patient Experience	15%	15%
Classification Anomalies	15%	15%
Claim Anomalies	15%	15%
Control Procedures	15%	15%
Number / Type of Patient Exposures.	15%	15%
Organizational Size / Structure	15%	15%
Medical Standards, Quality & Claim Review	15%	15%
Other Risk Management Practices and Procedures	15%	15%
Training, Accreditation & Credentialing	15%	15%
Record – Keeping Practices	15%	15%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	15%	15%

**F. Membership Credit**

1. A 5% premium credit may be given to those insureds who are members of a qualified association.
2. Qualified associations are subject to Company approval.

**G. Claim Free Credits**

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit according to the following table.

Years Claim Free at Renewal	Credit
less than 3	0%
3 to 4	5%
5 to 7	10%
8 to 9	15%
10 or more	20%

2. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.
3. Insureds converting coverage to the Company, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with the Company guidelines.
4. Years the insured was working part-time will not be considered in the determination of years claim free.

**H. Aggregate Credit Rule**

1. The application of all approved credits, except for claims free discounts, shall not exceed 50% for any one insured.
2. This Aggregate Credit Rule does not apply to Part-Time Practice or Leave of Absence Credits.

**I. Pre-Payment of Premium Credit**

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An insured who pre-pays the entire annual premium in cash on or before the effective date of the then-current policy term will be entitled to a premium credit of 3%.

**VII. OPTIONAL COVERAGES**

**A. Locum Tenens Physician**

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Coverage shall extend for a maximum of 30 days during any one policy period beginning with the first assignment, regardless of the number of substitutes.

**B. Corporation/Partnership/Professional Association Charge**

1. If coverage is provided on a separate limit of liability basis, then a separate Organization Policy will be issued. The premium is computed as either (1) the average of the annual mature claims made premiums applicable to the individual physicians in the group, or (2) 10% of the total of the individuals' annual premiums for the current policy period.
2. If a solo-practitioner desires coverage for the corporation/partnership/professional association, coverage can be provided for no additional premium charge, in which case the practitioner and the corporation/partnership/association share in the limit of liability.

**C. Extended Reporting ("Tail") Policy**

1. A physician or other named insured may purchase an extension of coverage, called an Extended Reporting Policy (or "Tail" policy). This policy provides coverage for claims reported after the termination of a claims made policy..

The physician or other named insured may purchase an Extended Reporting Policy by requesting this coverage in writing and paying the premium within thirty (30) days after the termination of coverage.

2. The premium for an Extended Reporting Policy will be calculated by applying a factor of 200% to the annual claims made premium in effect at the time that the Extended Reporting Policy is issued.

The premium for the extended reporting period endorsement is fully earned. In addition, full and timely payment of the premium will be expected prior to the Company's obligation to provide an Extended Reporting Policy. However, upon request, the Company may consider allowing payment terms for a twelve-month period pursuant to the quarterly and monthly payment options provided for under Section One, Paragraph XI of this Rating Manual, in which case a finance charge equal to 5% of the premium for the Extended Reporting Policy will be assessed.

3. The Extended Reporting Policy:
  - a. does not extend the policy period;
  - b. continues for an unlimited period;
  - c. does not extend the scope of coverage provided under this policy and applies only to otherwise covered claims or incident(s) which result from rendering or failure to render professional services on or after the retroactive date and before the end of the final claims made policy period, of which written notice is received by the Company during the extended reporting period.

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- d. cannot be canceled for any reason other than non-payment of the entire premium.

4. Limits of Liability

The Extended Reporting Policy carries with it one set of limits of liability, which limits are identical to the limits on the policy applicable to the final claims made policy period.

5. The Extended Reporting Policy will be provided and the premium charge will be waived by the Company if, during the policy period:
- a. the physician dies;
  - b. the physician completely and permanently retires from the clinical practice of medicine, as determined by the Company, and has been continuously insured with the Company, under a claims made policy for the previous five (5) years prior to retirement.
  - c. the physician becomes permanently and totally disabled.

The physician or his/her representative must notify the Company of any such death, disability or retirement within thirty (30) days of such event, and provide certification of death, disability or retirement, and such other proof as the Company may request.

If any named insured or additional named insured(s) returns to active clinical practice of medicine, as determined by the Company, after receiving an Extended Reporting Policy for which the Company waived the premium due to disability or retirement, the Company reserves the right, in its sole discretion, to rescind the premium waiver and to collect any premium due.

6. The otherwise applicable premium for an Extended Reporting Policy will be reduced according to the consecutive years of the physician's coverage by the Company immediately prior to the date the Extended Reporting Policy takes effect, as follows:

Years of Coverage with the Company	Discount Percentage
One	20%
Two	40%
Three	60%
Four	80%

**ILLINOIS STATE RATE PAGE  
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**I. PHYSICIAN CLASSIFICATION PLAN**

**A. Specialty Class Assignments**

Class	Specialty
1	Allergy, Public Health, Administrative Medicine, Aerospace Medicine, Physical Medicine/Rehabilitation
2	Dermatology - No Surgery, Forensic/Legal Medicine, General Preventive Medicine, Occupational Medicine, Ophthalmology - No Surgery, Otorhinolaryngology - No Surgery
3	Geriatrics - No Surgery, Pathology, Psychiatry (Excl. Shock Therapy), Rheumatology
4	Dermatology - Minor Surgery, Family/General Practice - No Surgery, Endocrinology - No Surgery, Hematology/Oncology - No Surgery, Industrial Medicine, Ophthalmology - Minor Surgery, Psychiatry (Incl. Shock Therapy), Pediatrics - No Surgery, Nuclear Medicine
5	Dermatology – Surgery, Diabetes, Urology - No Surgery, Otorhinolaryngology – No Surgery
6	Cardiovascular - No Surgery, Hematology/Oncology - Minor Surgery, Infectious Disease - No Surgery, Gynecology - No Surgery, Hospitalist, Nephrology - No Surgery, Ophthalmology – Surgery, Plastic Surgery – No Surgery, General Surgery – No Surgery
7	Anesthesiology, Pain Management, , Diagnostic Radiology - No Surgery, Internal Medicine - No Surgery
8	Geriatrics - Minor Surgery, Gastroenterology, Infectious Disease - Minor Surgery, Endocrinology - Minor Surgery, Nephrology - Minor Surgery, , Otorhinolaryngology - Minor Surgery, Pulmonary Diseases, Radiation Oncology, Radiation Therapy, Urology - Minor Surgery, Orthopedic Surgery – No Surgery, Cardiac Surgery – No Surgery, Vascular Surgery – No Surgery, Thoracic Surgery – No Surgery
9	Family/General Practice - Minor Surgery, Internal Medicine - Minor Surgery, Urgent Care, Neurology - No Surgery, Podiatry Surgery, Diagnostic Radiology - Minor Surgery, Pediatrics - Minor Surgery
10	Urology – Surgery, Neurosurgery - No Surgery
11	Cardiovascular - Minor Surgery (Left Heart Catheterization), Cardiovascular - Minor Surgery (Right Heart Catheterization), Gynecology - Minor Surgery, Intensive Care Medicine, Neurology - Minor Surgery, Otorhinolaryngology - Surgery (Excl. Plastic), Diagnostic Radiology- Surgery
12	Colon & Rectal Surgery, Family/General Practice - Major Surgery, Gynecological Surgery
13	Head & Neck Surgery, Emergency Medicine - Minor Surgery
14	Emergency Medicine - Major Surgery
15	General Surgery, Hand Surgery, Abdominal Surgery, Pediatric Surgery
16	Orthopedic Surgery - Excl. Spine, Plastic Surgery, Otorhinolaryngology - Surgery (Incl. Plastic)
17	Neonatology
18	Cardiac Surgery, Vascular Surgery, Traumatic Surgery, Thoracic Surgery
19	Obstetrics - Surgery, OB/GYN - Surgery, Orthopedic Surgery - Incl. Spine
20	Neurosurgery

The rate for coverage for a Certified Registered Nurse Anesthetist (CRNA) is determined by applying a factor of 15% to either (1) the annual individual policy premium for an anesthesiologist in a solo practice associated with the CRNA(s) or (2) the average annual individual policy premiums for all the anesthesiologists in a group practice associated with the CRNA(s).

**ILLINOIS STATE RATE PAGE  
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**B. Class Factors**

Class	Factor	Class	Factor
1	0.550	11	1.850
2	0.667	12	2.150
3	0.800	13	2.400
4	1.000	14	2.700
5	1.050	15	3.000
6	1.167	16	3.300
7	1.250	17	3.600
8	1.400	18	4.000
9	1.550	19	4.400
10	1.650	20	6.500

**II. TERRITORY FACTORS**

Territory	Factor	Counties
1	1.000	Cook, Jackson, Madison, St. Clair, Will
2	0.900	Lake, Vermilion
3	0.850	Kane, McHenry, Winnebago
4	0.750	DuPage, Kankakee, Macon
5	0.700	Bureau, Champaign, Coles, DeKalb, Effingham, La Salle, Ogle, Randolph
6	0.600	Grundy, Sangamon
7	0.475	Peoria
8	0.525	Remainder of State

**III. BASE RATE**

The mature claims-made rate for the base territory (i.e. territory 1), base classification (i.e. class 4) and the basic limit of liability (i.e. \$1,000,000/\$3,000,000) is \$16,500.

**IV. SCHEDULE RATING MAXIMUM SURCHARGE**

The schedule rating maximum debit is 50%.

<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons		
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing		
<b>Project Name/Number:</b>	/		

## Supporting Document Schedules

<b>Satisfied - Item:</b>	Explanatory Memorandum
<b>Comments:</b>	New rating manual filing for 2014. Changes create neither a reate increase or decrease.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Form RF3 - (Summary Sheet)
<b>Bypass Reason:</b>	New rating manual filing for 2014. Changes create neither a reate increase or decrease.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Certification
<b>Comments:</b>	The rates have been certified.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Manual
<b>Comments:</b>	
<b>Attachment(s):</b>	RATING MANUAL - PROPOSED 2014 CLEAN.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Bypassed - Item:</b>	Request to Maintain Data as Trade Secret Information
<b>Bypass Reason:</b>	No request to keep filing as trade secret.
<b>Attachment(s):</b>	
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>Satisfied - Item:</b>	Susan Bowen
<b>Comments:</b>	
<b>Attachment(s):</b>	RATING MANUAL - PROPOSED 2014 REDLINE.pdf
<b>Item Status:</b>	
<b>Status Date:</b>	

<b>SERFF Tracking #:</b>	DDIC-129211551	<b>State Tracking #:</b>	DDIC-129211551	<b>Company Tracking #:</b>	
<b>State:</b>	Illinois	<b>Filing Company:</b>	Doctors Direct Insurance, Inc.		
<b>TOI/Sub-TOI:</b>	11.2 Med Mal-Claims Made Only/11.2023 Physicians & Surgeons				
<b>Product Name:</b>	DDI 2014 Rate and Rule Filing				
<b>Project Name/Number:</b>	/				

**DOCTORS DIRECT INSURANCE, INC.**

PHYSICIANS AND SURGEONS  
PROFESSIONAL LIABILITY INSURANCE

RATING MANUAL

ILLINOIS

**RATING MANUAL  
FOR  
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

**SECTION ONE – GENERAL RULES**

**I. APPLICATION OF MANUAL**

This manual provides rules, rates, premiums, classifications and territories that will be used by Doctors Direct Insurance, Inc. ("the Company") in providing Professional Liability to Physicians and Surgeons.

**II. COVERAGE FORM**

All policies will be written on a claims made basis.

**III. POLICY TERM**

Policies will be written for a term of one year, and renewed annually thereafter. The policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year for a short term policy period.

**IV. PREMIUM COMPUTATION**

A. Premiums at policy inception will be computed using rules, rates and rating plan in effect at that time.

B. When a policy is issued for other than an annual term, the premiums will be computed on a pro-rata basis.

**V. FACTORS OR MULTIPLIERS**

A. Unless otherwise indicated, factors or multipliers are to be applied consecutively and not added together.

B. Rate Modifications listed as % credits are applied multiplicatively as follows: rate x (1 – credit %) or rate x (1 + debit %).

**VI. POLICY WRITING MINIMUM PREMIUM**

The minimum annual premium shall be \$250 unless otherwise specified.

**VII. WHOLE DOLLAR RULE**

The final premium for each physician or surgeon for will be rounded to the nearest whole dollar as follows:

A. Any value involving \$.50 or more will be rounded up to the next highest whole dollar amount.

B. Any value involving \$.49 or less will be rounded down to the next lowest whole dollar amount.

**VIII. ADDITIONAL PREMIUM CHARGES**

A. All changes or additions involving additional premiums will be pro-rated based upon the effective date of the change.

B. The rates and rules that were in effect at the inception date of the policy period are to be used in all additional premium calculations. After computing the additional premium, charge the amount applicable from the effective date of the change.

C. Additional premiums of \$25 or less may be waived. This waiver only applies to charges due on the effective date of change endorsements.

**IX. RETURN PREMIUMS**

Return premiums are computed using rates in effect at the time the return premium is computed. Return premiums are computed pro rata and rounded in accordance with the whole dollar rule when any exposure is deleted, or an amount of insurance is reduced.

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**X. POLICY CANCELLATIONS**

Return premiums for cancellations initiated by either the Company or the insured will be computed on a pro-rata basis, rounded to the next higher whole dollar.

**XI. PREMIUM PAYMENT PLANS**

The Company will offer the insured three (3) premium payment plans for every policy period.

Quarterly Installment Option

- a. An initial down payment of 25% of the total premium due at policy inception;
- b. The remaining premium spread equally among the second, third, and fourth installments and due 3, 6, and 9 months from policy inception, respectively;
- c. Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

Monthly Installment Option

- a. An initial down payment of 1/12<sup>th</sup> of the total premium due at policy inception;
- b. The remaining premium spread equally among eleven (11) monthly installments and due each month on the respective date equal to the date of the month in which the policy incepts.

Annual Pre-payment Option

See Section Two, Paragraph VI, Item I of this Rating Manual.

**SECTION TWO – RATING RULES**

**I. SPECIALTY CLASSIFICATIONS**

- A. Each physician is assigned a classification code according to his/her specialty. The specialty classifications and their associated rating factors are shown on the State Rate Page.
- B. For the purpose of determining each physician's specialty designation:
  1. The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia), and who do not ordinarily assist in surgical procedures.
  2. The terms "minor surgery" and "major surgery" may apply to general practitioners and specialists.
- C. The Company will assign specialty class based on the practice profile and procedures noted in the physician's application. The company may blend the rates of two or more specialty classifications based on the practice profile and procedures noted in the physician's application.
- D. If a physician's specialty is not listed on the State Rate Page, the physician will be assigned to the classification that applies to the most similar specialty listed.

**II. TERRITORIES**

- A. Territory assignments are based on each individual insured's practice as insured by the Company. Portions of the practice that are not insured by the Company are not considered.
- B. If an insured practices in two or more territories, the company may blend the rates of the applicable territories.
- C. The territory definitions and associated rating factors are shown on the State Rate Page.

**III. LIMITS OF LIABILITY**

**RATING MANUAL  
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- A. Basic Limits of Liability for Professional Liability Claims Made coverage under this program shall be \$1,000,000 Per Claim/\$3,000,000 Annual Aggregate.
- B. Alternate limits of liability are available. The limit options and associated rating factors are shown in the table below:

Limit of Liability		Limit Factor
Per Claim	Annual Aggregate	
\$250,000	\$750,000	0.640
\$500,000	\$1,500,000	0.780
\$1,000,000	\$1,000,000	0.970
\$1,000,000	\$3,000,000	1.000

- C. For limits greater than \$1,000,000 Per Claim / \$3,000,000 Annual Aggregate, refer to company.

**IV. PRIOR ACTS COVERAGE**

- A. The claims made coverage retroactive date is the initial effective date of continuous coverage by the Company, unless the Company and the insured agree that the retroactive date should precede the initial policy effective date.
- B. Once established, the retroactive date may be advanced only at the request of the insured or with the insured's written acknowledgment.
- C. When prior acts coverage is requested, the claims made year applicable is determined based on the retroactive date and the policy effective date as follows:
1. Determine the number of years between the retroactive date and the policy effective date. This figure is the number of years of prior exposure. Any fractional year difference between the retroactive date and the effective date is calculated on a daily pro-rata basis.
  2. The claims-made year is the years of prior exposure plus 1.
  3. For fractional claims-made years, the applicable claims-made step factor is calculated using straight line interpolation between factors for surrounding claims-made years.
- D. The following claims-made step factors are applied to the premium.

Claims-Made Year	Step Factor
1	0.300
2	0.550
3	0.775
4	0.925
5+	1.000

**V. BASE RATE**

The base rate is shown in the State Rate Page.

**VI. RATE MODIFICATIONS**

**A. Part Time Physicians**

1. Any insured whom the company determines to be practicing as a part-time practitioner will be eligible for a reduction in the otherwise applicable rate for that specialty. The credit for a part time practitioner is 25% for 10-20 hours per week and 50% for fewer than 10 hours per week.
2. The part-time credit is not applied to any Extended Reporting ("Tail") Policy rating unless the insured was rated part-time for at least 24 months prior to the effective date of an Extended Reporting Period Endorsement.

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3. No other credits are to apply concurrent with this rule except risk management and membership association credits.

**B. New Physician**

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
  - a. Residency;
  - b. Fellowship program in their medical specialty;
  - c. Fulfillment of a military obligation in remuneration for medical school tuition;
  - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A reduced rate will be applied in accordance with the credits shown in the table below:

Year of Practice	Credit
1 <sup>st</sup>	50%
2 <sup>nd</sup>	30%
3 <sup>rd</sup>	15%
4 <sup>th</sup>	0%

**C. Physician's Leave of Absence**

1. A physician who becomes disabled, or is on leave of absence for a continuous period of up to 180 days, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.
3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.
4. A written request must be received by the Company in order to be eligible for the restricted coverage and rate reduction.
5. A premium credit of 75% will apply during the period of disability or leave of absence.
6. The Company may extend the credit for a leave of absence beyond 180 days if circumstances so warrant.

**D. Physicians Military Leave of Absence**

1. A physician, who is on military leave of absence may be eligible for restricted coverage at no premium charge during the leave of absence period. This will apply retroactively to the first day of the leave of absence. Only one application of this credit may be applied to an annual policy period.
2. A written request must be received by the Company within 30 days of the first day of the disability or leave of absence, in order to be eligible for the restricted coverage and premium waiver.

**E. Schedule Rating**

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

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The premium for a policy may be modified in accordance with a maximum credit or debit modification indicated on the State Rate Page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the following specific considerations.

Characteristics	Max Credit	Max Debit
Cumulative Years of Patient Experience	15%	15%
Classification Anomalies	15%	15%
Claim Anomalies	15%	15%
Control Procedures	15%	15%
Number / Type of Patient Exposures.	15%	15%
Organizational Size / Structure	15%	15%
Medical Standards, Quality & Claim Review	15%	15%
Other Risk Management Practices and Procedures	15%	15%
Training, Accreditation & Credentialing	15%	15%
Record – Keeping Practices	15%	15%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	15%	15%

**F. Membership Credit**

1. A 5% premium credit may be given to those insureds who are members of a qualified association.
2. Qualified associations are subject to Company approval.

**G. Claim Free Credits**

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit according to the following table.

Years Claim Free at Renewal	Credit
less than 3	0%
3 to 4	5%
5 to 7	10%
8 to 9	15%
10 or more	20%

2. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.
3. Insureds converting coverage to the Company, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with the Company guidelines.
4. Years the insured was working part-time will not be considered in the determination of years claim free.

**H. Aggregate Credit Rule**

1. The application of all approved credits, except for claims free discounts, shall not exceed 50% for any one insured.
2. This Aggregate Credit Rule does not apply to Part-Time Practice or Leave of Absence Credits.

**I. Pre-Payment of Premium Credit**

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An insured who pre-pays the entire annual premium in cash on or before the effective date of the then-current policy term will be entitled to a premium credit of 3%.

**VII. OPTIONAL COVERAGES**

**A. Locum Tenens Physician**

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Coverage shall extend for a maximum of 30 days during any one policy period beginning with the first assignment, regardless of the number of substitutes.

**B. Corporation/Partnership/Professional Association Charge**

1. If coverage is provided on a separate limit of liability basis, then a separate Organization Policy will be issued. The premium is computed as either (1) the average of the annual mature claims made premiums applicable to the individual physicians in the group, or (2) 10% of the total of the individuals' annual premiums for the current policy period.
2. If a solo-practitioner desires coverage for the corporation/partnership/professional association, coverage can be provided for no additional premium charge, in which case the practitioner and the corporation/partnership/association share in the limit of liability.

**C. Extended Reporting ("Tail") Policy**

1. A physician or other named insured may purchase an extension of coverage, called an Extended Reporting Policy (or "Tail" policy). This policy provides coverage for claims reported after the termination of a claims made policy..

The physician or other named insured may purchase an Extended Reporting Policy by requesting this coverage in writing and paying the premium within thirty (30) days after the termination of coverage.

2. The premium for an Extended Reporting Policy will be calculated by applying a factor of 200% to the annual claims made premium in effect at the time that the Extended Reporting Policy is issued.

The premium for the extended reporting period endorsement is fully earned. In addition, full and timely payment of the premium will be expected prior to the Company's obligation to provide an Extended Reporting Policy. However, upon request, the Company may consider allowing payment terms for a twelve-month period pursuant to the quarterly and monthly payment options provided for under Section One, Paragraph XI of this Rating Manual, in which case a finance charge equal to 5% of the premium for the Extended Reporting Policy will be assessed.

3. The Extended Reporting Policy:
  - a. does not extend the policy period;
  - b. continues for an unlimited period;
  - c. does not extend the scope of coverage provided under this policy and applies only to otherwise covered claims or incident(s) which result from rendering or failure to render professional services on or after the retroactive date and before the end of the final claims made policy period, of which written notice is received by the Company during the extended reporting period.

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- d. cannot be canceled for any reason other than non-payment of the entire premium.

4. Limits of Liability

The Extended Reporting Policy carries with it one set of limits of liability, which limits are identical to the limits on the policy applicable to the final claims made policy period.

5. The Extended Reporting Policy will be provided and the premium charge will be waived by the Company if, during the policy period:
- a. the physician dies;
  - b. the physician completely and permanently retires from the clinical practice of medicine, as determined by the Company, and has been continuously insured with the Company, under a claims made policy for the previous five (5) years prior to retirement.
  - c. the physician becomes permanently and totally disabled.

The physician or his/her representative must notify the Company of any such death, disability or retirement within thirty (30) days of such event, and provide certification of death, disability or retirement, and such other proof as the Company may request.

If any named insured or additional named insured(s) returns to active clinical practice of medicine, as determined by the Company, after receiving an Extended Reporting Policy for which the Company waived the premium due to disability or retirement, the Company reserves the right, in its sole discretion, to rescind the premium waiver and to collect any premium due.

6. The otherwise applicable premium for an Extended Reporting Policy will be reduced according to the consecutive years of the physician's coverage by the Company immediately prior to the date the Extended Reporting Policy takes effect, as follows:

Years of Coverage with the Company	Discount Percentage
One	20%
Two	40%
Three	60%
Four	80%

**ILLINOIS STATE RATE PAGE  
FOR  
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

**I. PHYSICIAN CLASSIFICATION PLAN**

**A. Specialty Class Assignments**

Class	Specialty
1	Allergy, Public Health, Administrative Medicine, Aerospace Medicine, Physical Medicine/Rehabilitation
2	Dermatology - No Surgery, Forensic/Legal Medicine, General Preventive Medicine, Occupational Medicine, Ophthalmology - No Surgery, Otorhinolaryngology - No Surgery
3	Geriatrics - No Surgery, Pathology, Psychiatry (Excl. Shock Therapy), Rheumatology
4	Dermatology - Minor Surgery, Family/General Practice - No Surgery, Endocrinology - No Surgery, Hematology/Oncology - No Surgery, Industrial Medicine, Ophthalmology - Minor Surgery, Psychiatry (Incl. Shock Therapy), Pediatrics - No Surgery, Nuclear Medicine
5	Dermatology – Surgery, Diabetes, Urology - No Surgery, Otorhinolaryngology – No Surgery
6	Cardiovascular - No Surgery, Hematology/Oncology - Minor Surgery, Infectious Disease - No Surgery, Gynecology - No Surgery, Hospitalist, Nephrology - No Surgery, Ophthalmology – Surgery, Plastic Surgery – No Surgery, General Surgery – No Surgery
7	Anesthesiology, Pain Management, , Diagnostic Radiology - No Surgery, Internal Medicine - No Surgery
8	Geriatrics - Minor Surgery, Gastroenterology, Infectious Disease - Minor Surgery, Endocrinology - Minor Surgery, Nephrology - Minor Surgery, , Otorhinolaryngology - Minor Surgery, Pulmonary Diseases, Radiation Oncology, Radiation Therapy, Urology - Minor Surgery, Orthopedic Surgery – No Surgery, Cardiac Surgery – No Surgery, Vascular Surgery – No Surgery, Thoracic Surgery – No Surgery
9	Family/General Practice - Minor Surgery, Internal Medicine - Minor Surgery, Urgent Care, Neurology - No Surgery, Podiatry Surgery, Diagnostic Radiology - Minor Surgery, Pediatrics - Minor Surgery
10	Urology – Surgery, Neurosurgery - No Surgery
11	Cardiovascular - Minor Surgery (Left Heart Catheterization), Cardiovascular - Minor Surgery (Right Heart Catheterization), Gynecology - Minor Surgery, Intensive Care Medicine, Neurology - Minor Surgery, Otorhinolaryngology - Surgery (Excl. Plastic), Diagnostic Radiology- Surgery
12	Colon & Rectal Surgery, Family/General Practice - Major Surgery, Gynecological Surgery
13	Head & Neck Surgery, Emergency Medicine - Minor Surgery
14	Emergency Medicine - Major Surgery
15	General Surgery, Hand Surgery, Abdominal Surgery, Pediatric Surgery
16	Orthopedic Surgery - Excl. Spine, Plastic Surgery, Otorhinolaryngology - Surgery (Incl. Plastic)
17	Neonatology
18	Cardiac Surgery, Vascular Surgery, Traumatic Surgery, Thoracic Surgery
19	Obstetrics - Surgery, OB/GYN - Surgery, Orthopedic Surgery - Incl. Spine
20	Neurosurgery

The rate for coverage for a Certified Registered Nurse Anesthetist (CRNA) is determined by applying a factor of 15% to either (1) the annual individual policy premium for an anesthesiologist in a solo practice associated with the CRNA(s) or (2) the average annual individual policy premiums for all the anesthesiologists in a group practice associated with the CRNA(s).

**ILLINOIS STATE RATE PAGE  
FOR  
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

**B. Class Factors**

Class	Factor	Class	Factor
1	0.550	11	1.850
2	0.667	12	2.150
3	0.800	13	2.400
4	1.000	14	2.700
5	1.050	15	3.000
6	1.167	16	3.300
7	1.250	17	3.600
8	1.400	18	4.000
9	1.550	19	4.400
10	1.650	20	6.500

**II. TERRITORY FACTORS**

Territory	Factor	Counties
1	1.000	Cook, Jackson, Madison, St. Clair, Will
2	0.900	Lake, Vermilion
3	0.850	Kane, McHenry, Winnebago
4	0.750	DuPage, Kankakee, Macon
5	0.700	Bureau, Champaign, Coles, DeKalb, Effingham, La Salle, Ogle, Randolph
6	0.600	Grundy, Sangamon
7	0.475	Peoria
8	0.525	Remainder of State

**III. BASE RATE**

The mature claims-made rate for the base territory (i.e. territory 1), base classification (i.e. class 4) and the basic limit of liability (i.e. \$1,000,000/\$3,000,000) is \$16,500.

**IV. SCHEDULE RATING MAXIMUM SURCHARGE**

The schedule rating maximum debit is 50%.

**DOCTORS DIRECT INSURANCE, INC.**

PHYSICIANS AND SURGEONS  
PROFESSIONAL LIABILITY INSURANCE

RATING MANUAL

ILLINOIS

**RATING MANUAL  
FOR  
PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE**

SECTION ONE – GENERAL RULES

I. APPLICATION OF MANUAL

This manual provides rules, rates, premiums, classifications and territories that will be used by Doctors Direct Insurance, Inc. ("the Company") in providing Professional Liability to Physicians and Surgeons.

II. COVERAGE FORM

All policies will be written on a claims made basis.

III. POLICY TERM

Policies will be written for a term of one year, and renewed annually thereafter. The policy term may be extended beyond one year subject to underwriting guidelines and state limitations. Coverage may also be written for a period of time less than one year for a short term policy period.

IV. PREMIUM COMPUTATION

A. Premiums at policy inception will be computed using rules, rates and rating plan in effect at that time.

B. When a policy is issued for other than an annual term, the premiums will be computed on a pro-rata basis.

V. FACTORS OR MULTIPLIERS

A. Unless otherwise indicated, factors or multipliers are to be applied consecutively and not added together.

B. Rate Modifications listed as % credits are applied multiplicatively as follows: rate x (1 – credit %) or rate x (1 + debit %).

VI. POLICY WRITING MINIMUM PREMIUM

The minimum annual premium shall be \$250 unless otherwise specified.

VII. WHOLE DOLLAR RULE

The final premium for each physician or surgeon for will be rounded to the nearest whole dollar as follows:

A. Any value involving \$.50 or more will be rounded up to the next highest whole dollar amount.

B. Any value involving \$.49 or less will be rounded down to the next lowest whole dollar amount.

VIII. ADDITIONAL PREMIUM CHARGES

A. All changes or additions involving additional premiums will be pro-rated based upon the effective date of the change.

B. The rates and rules that were in effect at the inception date of the policy period are to be used in all additional premium calculations. After computing the additional premium, charge the amount applicable from the effective date of the change.

C. Additional premiums of \$25 or less may be waived. This waiver only applies to charges due on the effective date of change endorsements.

IX. RETURN PREMIUMS

A. Return premiums are computed using rates ~~and rules~~ in effect at ~~policy inception~~the time the return premium is computed.

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~~B. Return premiums are computed pro rata and rounded in accordance with the whole dollar rule when any exposure is deleted, or an amount of insurance is reduced.~~

~~C. Retain the Policy Writing Minimum Premium.~~

~~D. Return premiums of \$25 or less may be waived. However, the premium will be returned if requested in writing by the insured.~~

**X. POLICY CANCELLATIONS**

~~A. Return premiums for cancellations initiated by either the Company or the insured will be computed on a pro-rata basis, rounded to the next higher whole dollar.~~

~~B. Return premiums for cancellations initiated by the Insured will be computed on a 90% of pro-rata basis, rounded to the next higher whole dollar.~~

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**XI. PREMIUM PAYMENT PLANS**

The Company will offer the insured athree (3) premium payment plans for every policy period.

Quarterly Installment Option

a. An initial down payment of ~~no more than 40~~25% of the ~~estimated~~ total premium due at policy inception;

b. The remaining premium spread equally among the second, third, and fourth installments, with the maximum for such installments set at 30% of the estimated total premium, and due 3, 6, and 9 months from policy inception, respectively;

~~c. No interest charges;~~

~~d. Installment charges or fees of no more than 1% of the total premium or \$25.00, whichever is less;~~

~~ec.~~ Additional premium resulting from changes to the policy shall be spread equally over the remaining installments, if any. If there are no remaining installments, additional premium resulting from changes to a policy may be billed immediately as a separate transaction.

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Monthly Installment Option

a. An initial down payment of 1/12<sup>th</sup> of the total premium due at policy inception;

b. The remaining premium spread equally among eleven (11) monthly installments and due each month on the respective date equal to the date of the month in which the policy incepts.

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Annual Pre-payment Option

See Section Two, Paragraph VI, Item I of this Rating Manual.

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**SECTION TWO – RATING RULES**

**I. SPECIALTY CLASSIFICATIONS**

A. Each physician is assigned a classification code according to ~~their~~his/her specialty. ~~—~~The specialty classifications and their associated rating factors are shown on the State Rate Page.

B. For the purpose of determining each physician's specialty designation:

1. The term "no surgery" applies to general practitioners and specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses, removal of superficial growths, or suturing of skin and superficial fascia), and who do not ordinarily assist in surgical procedures.

2. The terms "minor surgery" and "major surgery" may apply to general practitioners and specialists.

C. The Company will assign specialty class based on the practice profile and procedures noted in the physician's application. ~~—~~ The company may blend the rates of two or more specialty

**RATING MANUAL  
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classifications based on the practice profile and procedures noted in the physician's application.

- D. If a physician's specialty is not listed on the State Rate Page, ~~assign~~ the physician will be assigned to the classification that applies to the most similar specialty listed.

**II. TERRITORIES**

- A. Territory assignments are based on each individual insured's practice as insured by the Company. Portions of the practice that are not insured by the Company are not considered.
- B. If an insured practices in two or more territories, the company may blend the rates of the applicable territories.
- C. The territory definitions and associated rating factors are shown on the State Rate Page.

**III. LIMITS OF LIABILITY**

- A. Basic Limits of Liability for Professional Liability Claims Made coverage under this program shall be \$1,000,000 Per Claim/\$3,000,000 Annual Aggregate.
- B. Alternate limits of liability are available. The limit options and associated rating factors are shown in the table below:

Limit of Liability		Limit Factor
Per Claim	Annual Aggregate	
\$250,000	\$750,000	0.640
\$500,000	\$1,500,000	0.780
\$1,000,000	\$1,000,000	0.970
\$1,000,000	\$3,000,000	1.000

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- C. For limits greater than \$1,000,000 Per Claim / \$3,000,000 Annual Aggregate, refer to company.

**IV. PRIOR ACTS COVERAGE**

- A. The claims made coverage retroactive date is the initial effective date of continuous coverage by the Company, unless the Company and the insured agree that the retroactive date should precede the initial policy effective date.
- B. Once established, the retroactive date may be advanced only at the request of the insured or with the insured's written acknowledgment.
- C. When prior acts coverage is requested, the claims made year applicable is determined based on the retroactive date and the policy effective date as follows:
1. Determine the number of years between the retroactive date and the policy effective date. This figure is the number of years of prior exposure. Any fractional year difference between the retroactive date and the effective date is calculated on a daily pro-rata basis.
  2. The claims-made year is the years of prior exposure plus 1.
  3. For fractional claims-made years, the applicable claims-made step factor is calculated using straight line interpolation between factors for surrounding claims-made years.
- D. The following claims-made step factors are applied to the premium.

Claims-Made Year	Step Factor
1	0.300
2	0.550
3	0.775
4	0.925
5+	1.000

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**V. BASE RATE**

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The base rate is shown in the State Rate Page.

**VI. RATE MODIFICATIONS**

**A. Part Time Physicians**

1. Any insured whom the company determines ~~isto be work~~practicing as a part-time practitioner will be eligible for a reduction in the otherwise applicable rate for that specialty. The credit for a part time practitioner is 25% for 10-20 hours per week and 50% for fewer than 10 hours per week.
2. The part-time credit is not applied to ~~theany~~ Extended Reporting ~~Period Coverage~~("Tail") ~~Policy~~ rating unless the insured was rated part-time for ~~more than~~at least 24 months prior to the effective date of an Extended Reporting Period Endorsement.
3. No other credits are to apply concurrent with this rule except risk management and membership association credits.

**B. New Physician**

1. A "new" physician shall be a physician who has recently completed one of the following programs and will begin a full time practice for the first time:
  - a. Residency;
  - b. Fellowship program in their medical specialty;
  - c. Fulfillment of a military obligation in remuneration for medical school tuition;
  - d. Medical school or specialty training program.
2. To qualify for the credit, the applicant will be required to apply for a reduced rate within six months after the completion of any of the above programs.
3. A reduced rate will be applied in accordance with the credits shown in the table below:

Year of Practice	Credit
1 <sup>st</sup>	50%
2 <sup>nd</sup>	30%
3 <sup>rd</sup>	15%
4 <sup>th</sup>	0%

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**C. Physician's Leave of Absence**

1. A physician who becomes disabled, or is on leave of absence for a continuous period of ~~45~~up to 180 days, may be eligible for restricted coverage at a reduction to the applicable rate for the period of disability or leave of absence.
2. This will apply retroactively to the first day of disability or leave of absence.
3. Leave of absence may include time to enhance the medical practitioner's education, but does not include vacation time, and the insured is only eligible for one application of this credit for an annual policy period.
4. A written request must be received by the Company ~~within 30 days of the first day of the disability or leave of absence,~~ in order to be eligible for the restricted coverage and rate reduction.

5. A premium credit of 75% will apply during the period of disability or leave of absence.

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~~5-6.~~ The Company may extend the credit for a leave of absence beyond 180 days if circumstances so warrant.

**D. Physicians Military Leave of Absence**

**RATING MANUAL  
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1. A physician, who is on military leave of absence ~~for a continuous period of 45 days or more,~~ may be eligible for restricted coverage at no premium charge during the leave of absence period. This will apply retroactively to the first day of the leave of absence. Only one application of this credit may be applied to an annual policy period.
2. A written request must be received by the Company within 30 days of the first day of the disability or leave of absence, in order to be eligible for the restricted coverage and premium waiver.

**E. Schedule Rating**

The Company shall utilize a schedule of modifications to determine appropriate premiums for certain insureds, or groups of insureds, who in the opinion of the Company, uniquely qualify for such modifications because of factors not contemplated in the filed rate structure of the Company.

The premium for a policy may be modified in accordance with a maximum credit or debit modification indicated on the State Rate Page, and may be applied to recognize risk characteristics that are not reflected in the otherwise applicable premium. All modifications applied under this schedule rating plan are subject to periodic review. The modification shall be based on one or more of the following specific considerations.

Characteristics	Max Credit	Max Debit
Cumulative Years of Patient Experience	15%	15%
Classification Anomalies	15%	15%
Claim Anomalies	15%	15%
Control Procedures	15%	15%
Number / Type of Patient Exposures.	15%	15%
Organizational Size / Structure	15%	15%
Medical Standards, Quality & Claim Review	15%	15%
Other Risk Management Practices and Procedures	15%	15%
Training, Accreditation & Credentialing	15%	15%
Record – Keeping Practices	15%	15%
Utilization of Monitoring Equipment, Diagnostic Tests or Procedures	15%	15%

**F. Membership Credit**

1. A 5% premium credit may be given to those insureds who are members of a qualified association.
2. Qualified associations are subject to Company approval.

**G. Claim Free Credits**

1. If no claim has been attributed to an insured, the insured will be eligible for a premium credit according to the following table.

Years Claim Free at Renewal	Credit
less than 3	0%
3 to 4	5%
5 to 7	10%
8 to 9	15%
10 or more	20%

2. A claim under this policy shall not, for the purpose of this premium credit program, be construed to include instances of mistaken identity, blanket defendant listings, improper inclusion, or non-meritorious or frivolous claims.

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**RATING MANUAL  
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3. Insureds converting coverage to the Company, who were claim free while insured by another carrier, shall qualify for credit at the policy inception date in accordance with the Company guidelines.
4. Years the insured was working part-time will not be considered in the determination of years claim free.

**H. Large Group Rating**

- ~~1. A Group comprised of 10 members or more may be collectively rated.~~
- ~~2. Group is defined as any collective decision-making group / body of insureds who may be owners of, employed by or under contract with a specific and distinct corporation, partnership or association.~~
- ~~3. The premium for a Group will be determined by multiplying the group's manual premium by any credits or debits assigned to the Group under the Schedule Rating Plan, Deductible Credit Rule, or Self Insured Retention Credit Rule. The group's manual premium will equal the sum of the individual manual premium for each scheduled insured covered under the policy. The individual manual premium will equal the filed rate for the scheduled insured minus any applicable Part Time, Risk Management, or Leave of Absence credits. However, once the premium for the Group has been established, the Company may allocate that premium among the scheduled insureds based upon applicable underwriting criteria.~~

**I.H. Aggregate Credit Rule**

1. The application of all approved credits contained in this rating manual, except for claims free discounts, shall not exceed 50% for any one insured.
2. This Aggregate Credit Rule does not apply to Part-Time Practice or, Leave of Absence or Deductible Credits.

**J.I. Pre-Payment of Premium Credit**

An insured who pre-pays the entire annual premium in cash on or before the effective date of the then-current policy term will be entitled to a premium credit of 3%.

**VII. OPTIONAL COVERAGES**

**A. Locum Tenens Physician**

1. Coverage for a physician substituting for an insured physician will be limited to cover only professional services rendered on behalf of the insured physician for the specified time period. Locum Tenens will share in the insured physician's Limit of Liability. No additional charge will apply for this coverage.
2. The locum tenens physician must complete an application and submit it to the Company in advance for approval prior to the requested effective date of coverage.
3. Coverage shall extend for a maximum of 30 days during any one policy period beginning with the first assignment, regardless of the number of substitutes.

**B. Corporation/Partnership/Professional Association Charge**

1. If coverage is provided on a separate limit of liability basis, then a separate Organization Policy will be issued. ~~The premium is computed, per Corporation/Partnership/Professional Association, as one mature exposure unit of a non-surgical specialty classification that represents the prevailing specialty of the group practice plus the lesser of either 10% or the average of the developed physicians' premiums, as either (1) the average of the annual mature claims made premiums applicable to the individual physicians in the group, or (2) 10% of the total of the individuals' annual premiums for the current policy period.~~

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2. If a solo-practitioner desires coverage for the corporation/partnership/professional association, coverage can be provided for no additional premium charge, in which case the practitioner and the corporation/partnership/association share in the limit of liability.

C. Extended Reporting ~~("Tail") Period Endorsement Policy~~

~~1. A named insured who is a person, and any additional named insured(s), physician or other named insured may purchase an extension of coverage of at least twelve (12) months, called an eExtended rReporting period endorsement Policy (or "Tail" policy). This policy provides coverage for claims reported after the termination of a claims made policy, if the named insured and additional named insured(s) have complied with all terms and conditions of this policy, and:~~

- ~~a. this policy is cancelled or non-renewed for any reason; or  
b. 1. during the policy period any additional named insured(s) ceases to have a practice relationship with the named insured listed in item 1. of the Declarations Page.~~

~~The named insured or additional named insured(s) physician or other named insured must purchase an eExtended rReporting period endorsement Policy by requesting the extended reporting period endorsement this coverage in writing and paying the premium within thirty (30) days after the termination of coverage.~~

2. The premium for an eExtended rReporting period endorsement Policy will be calculated as follows by applying a factor of 200% to the annual claims made premium in effect at the time that the Extended Reporting Policy is issued:

- ~~a. 100% of the actual premium in effect at policy issuance for a 12-month extended reporting period;  
b. 160% of the actual premium in effect at policy issuance for a 24-month extended reporting period; or  
c. 190% of the actual premium in effect at policy issuance for a 36-month extended reporting period.  
d. 200% of the actual premium in effect at policy issuance for an unlimited extended reporting period.~~

~~The premium for the extended reporting period endorsement is fully earned; and. In addition,~~

~~Full and timely payment of the premium are conditions precedent will be expected prior to the Company's obligation to provide an eExtended rReporting period endorsement Policy. However, upon request, the Company may consider allowing payment terms for a twelve-month period pursuant to the quarterly and monthly payment options provided for under Section One, Paragraph XI of this Rating Manual, in which case a finance charge equal to 5% of the premium for the Extended Reporting Policy will be assessed.~~

3. The Extended Reporting ~~Period Endorsement Policy~~:

- ~~a. does not extend the policy period;  
a-b. continues for an unlimited period;  
b-c. does not extend the scope of coverage provided under this policy and applies only to otherwise covered claims or incident(s) which result from rendering or failure to render professional services on or after the retroactive date and before the end of the final claims made policy period, of which written notice is received by the Company during the extended reporting period.  
e-d. cannot be canceled for any reason other than non-payment of the entire premium.~~

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5. Limits of Liability

The ~~e~~Extended ~~r~~Reporting period ~~Policy has no separate~~ carries with it one set of limits of liability, ~~and does not increase the limits of liability which limits are identical to the limits on the policy applicable to the final claims made policy period.~~

6. ~~An~~The ~~e~~Extended ~~r~~Reporting period ~~endorsement~~ ~~Policy~~ will be provided and the premium charge will be waived by the Company if, during the policy period:

- a. ~~any named insured or additional named insured(s) the physician~~ dies;
- b. ~~named insured or additional named insured(s) the physician~~ completely and permanently retires from the clinical practice of medicine, as determined by the Company, and has been continuously insured with the Company, under a claims made policy for the ~~last previous~~ five (5) years ~~before prior to~~ retirement ~~and is at least 55 years of age.~~
- c. ~~any named insured or additional named insured(s) the physician~~ becomes permanently and totally disabled.

The insured physician or his ~~or~~ her representative must notify the Company of any such death, disability or retirement within thirty (30) days of such event, and provide certification of death, disability or retirement, and such other proof as the Company may request.

If any named insured or additional named insured(s) returns to active clinical practice of medicine, as determined by the Company, after receiving an ~~e~~Extended ~~r~~Reporting period ~~endorsement~~ ~~Policy~~ for which the Company waived the premium due to disability or retirement, the Company reserves the right, in its sole discretion, to rescind the premium waiver and to collect any premium due.

7. The otherwise applicable premium for an Extended Reporting Policy will be reduced according to the consecutive years of the physician's coverage by the Company immediately prior to the date the Extended Reporting Policy takes effect, as follows:

<u>Years of Coverage with the Company</u>	<u>Discount Percentage</u>
<u>One</u>	<u>20%</u>
<u>Two</u>	<u>40%</u>
<u>Three</u>	<u>60%</u>
<u>Four</u>	<u>80%</u>

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**I. PHYSICIAN CLASSIFICATION PLAN**

**A. Specialty Class Assignments**

Class	Specialty
1	Allergy, Public Health, Administrative Medicine, Aerospace Medicine, Physical Medicine/Rehabilitation
2	Dermatology - No Surgery, Forensic/Legal Medicine, General Preventive Medicine, Occupational Medicine, Ophthalmology - No Surgery, Otorhinolaryngology - No Surgery
3	Geriatrics - No Surgery, Pathology, Psychiatry (Excl. Shock Therapy), Rheumatology
4	Dermatology - Minor Surgery, Family/General Practice - No Surgery, Endocrinology - No Surgery, Hematology/Oncology - No Surgery, Industrial Medicine, Ophthalmology - Minor Surgery, Psychiatry (Incl. Shock Therapy), Pediatrics - No Surgery, Nuclear Medicine
5	Dermatology – Surgery, Diabetes, Urology - No Surgery, Otorhinolaryngology – No Surgery
6	Cardiovascular - No Surgery, Hematology/Oncology - Minor Surgery, Infectious Disease - No Surgery, Gynecology - No Surgery, Hospitalist, Nephrology - No Surgery, Ophthalmology – Surgery, Plastic Surgery – No Surgery, General Surgery – No Surgery
7	Anesthesiology, Pain Management, , Diagnostic Radiology - No Surgery, Internal Medicine - No Surgery
8	Geriatrics - Minor Surgery, Gastroenterology, Infectious Disease - Minor Surgery, Endocrinology - Minor Surgery, Nephrology - Minor Surgery, , Otorhinolaryngology - Minor Surgery, Pulmonary Diseases, Radiation Oncology, Radiation Therapy, Urology - Minor Surgery, Orthopedic Surgery – No Surgery, Cardiac Surgery – No Surgery, Vascular Surgery – No Surgery, Thoracic Surgery – No Surgery
9	Family/General Practice - Minor Surgery, Internal Medicine - Minor Surgery, Urgent Care, Neurology - No Surgery, Podiatry Surgery, Diagnostic Radiology - Minor Surgery, Pediatrics - Minor Surgery
10	Urology – Surgery, Neurosurgery - No Surgery
11	Cardiovascular - Minor Surgery (Left Heart Catheterization), Cardiovascular - Minor Surgery (Right Heart Catheterization), Gynecology - Minor Surgery, Intensive Care Medicine, Neurology - Minor Surgery, Otorhinolaryngology - Surgery (Excl. Plastic), Diagnostic Radiology- Surgery
12	Colon & Rectal Surgery, Family/General Practice - Major Surgery, Gynecological Surgery
13	Head & Neck Surgery, Emergency Medicine - Minor Surgery
14	Emergency Medicine - Major Surgery
15	General Surgery, Hand Surgery, Abdominal Surgery, Pediatric Surgery
16	Orthopedic Surgery - Excl. Spine, Plastic Surgery, Otorhinolaryngology - Surgery (Incl. Plastic)
17	Neonatology
18	Cardiac Surgery, Vascular Surgery, Traumatic Surgery, Thoracic Surgery
19	Obstetrics - Surgery, OB/GYN - Surgery, Orthopedic Surgery - Incl. Spine
20	Neurosurgery

The rate for coverage for a Certified Registered Nurse Anesthetist (CRNA) is determined by applying a factor of 15% to either (1) the annual individual policy premium for an anesthesiologist in a solo practice associated with the CRNA(s) or (2) the average annual individual policy premiums for all the anesthesiologists in a group practice associated with the CRNA(s).

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**B. Class Factors**

Class	Factor	Class	Factor
1	0.550	11	1.850
2	0.667	12	2.150
3	0.800	13	2.400
4	1.000	14	2.700
5	1.050	15	3.000
6	1.167	16	3.300
7	1.250	17	3.600
8	1.400	18	4.000
9	1.550	19	4.400
10	1.650	20	6.500

**II. TERRITORY FACTORS**

Territory	Factor	Counties
1	1.000	Cook, Jackson, Madison, St. Clair, Will
2	0.900	Lake, Vermilion
3	0.850	Kane, McHenry, Winnebago
4	0.750	DuPage, Kankakee, Macon
5	0.700	Bureau, Champaign, Coles, DeKalb, Effingham, La Salle, Ogle, Randolph
6	0.600	Grundy, Sangamon
7	0.475	Peoria
8	0.525	Remainder of State

**III. BASE RATE**

The mature claims-made rate for the base territory (i.e. territory 1), base classification (i.e. class 4) and the basic limit of liability (i.e. \$1,000,000/\$3,000,000) is \$16,500.

**IV. SCHEDULE RATING MAXIMUM SURCHARGE**

The schedule rating maximum debit/credit is +/-50% ~~with the exception of credits applied for Leave of Absence, Military Leave of Absence, or Restricted Practice.~~